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ABSTRACT

In a recent study, the mothers of 268 children who were in classes for educable mentally retarded in two public school districts in Southern California were interviewed. The responses of some of these mothers dramatize three issues: (1) biases in the assessment procedures used to label children as mentally retarded; (2) the stigmatization associated with special class placement; and, (3) inadequate programming. Disproportionately large numbers of black and Chicano children are labeled as mentally retarded by the public schools. Public schools rely more on IQ test scores than any other community agency. The schools label more persons as mentally retarded, share their labels with more other organizations, and label more persons with IQ's above 70 and with no physical disabilities than any other formal organization in the community. Proportionately more low status persons and persons from minority ethnic groups were defined as comprehensively retarded as the cutoff level for subnormality was raised. Stigmatization was a major concern of parents interviewed. Of a group of 108 children followed for several years and classified as retarded, only one in five ever returned to the regular class. Thus, many parents were justified in seeing the program as a "sentence of death." (Author/JM)

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Sociocultural Factors in the Educational Evaluation of Black and Chicano Children

Presented

At the 10th Annual Conference on
Civil and Human Rights of Educators and Students
Washington, D. C.
National Education Association
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by

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Author's Note: A more comprehensive and detailed analysis and report of the referral process, the clinical testing process, the assumptions and inferences of the clinician, and the pluralistic evaluation process discussed herein appear in a forthcoming volume entitled Labeling the Mentally Retarded.

The purpose of this conference is to examine the question of human rights in education. The importance of recognizing the rights of each child extends far beyond the school years. The schools are the primary social institution allocating persons to adult statuses and roles in American society. The kind and amount of education which a person has determines, to a large extent, whether he will participate in the mainstream of American life or be shunted into the byways. Educational decisions which systematically favor one group over another predetermine which group will occupy the seats of power and which group will remain powerless. It is this awesome responsibility which I would like to discuss with you this evening.

Although my research studies have been primarily in the area of mental retardation and the findings I will present this evening are based on those studies, I believe these findings have implications beyond the labeling and placement of children in classes for the mentally retarded in the public schools.

In a recent study, we interviewed the mothers of 268 children who were in classes for the educable mentally retarded in two public school districts in Southern California. The responses of some of these mothers illustrate, graphically, the three issues which I would like to address tonight; biases in the assessment procedures used to label children as mentally retarded; the stigmatization associated with special class placement; and inadequate programming. I will discuss each of these issues separately and will then present what appears to me to be viable alternatives to present procedures.

We turn first to the issue of systemic cultural biases in the diagnostic procedures used to label children as mentally retarded. Studies dating back to the 1930's have repeatedly demonstrated the cultural biases inherent in IQ tests and other standardized achievement measures. Yet, in spite of these studies, clinitions have continued to interpret children's performances on these tests as if there were no cultural biases and have never systematically taken socio-cultural differences into account when interpreting the meaning of a particular child's score. Consequently, we find many children in classes for the mentally retarded whose adaptive behavior, in nonacademic settings, clearly demonstrates that their problems are school specific and that they are not comprehensively incompetent.

John is a 16-year-old, Black boy who has been in classes for the educable mentally retarded for the past 8 years. He has an IQ of 83. When John's mother was asked to describe what he does on Saturdays and around the house and in the neighborhood, she gave the following reply:

> John works on weekends at the service station as an attendent. . . I would say he's a good mechanic. He likes to work on cars, changes the oil, helps with overhauling a car, and works on motorcycles. Sometimes he irons, washes dishes mops the floor, cuts the lawn, sweeps off the driveway, goes to the store, runs errands, vacuums the rugs, makes his own bed, and things like that. He's never still too much. He likes to be outdoors and likes to ride motorcycles. He plays basketball and football on Saturdays, works on cars, and then goes to bed.

Pete is a 14-year-old, Chicano boy with an IQ of 79 who has just been returned to regular classes after being in special education since he was 10 years old. His mother described him as follows:

> Pete is a very bright child, he's always thinking and doing something; he built a two-room tree house that is just beautiful. He is good at anything that needs putting together. He makes cars with motors, he makes them from old boxes, tires, wood, anything he can find. He makes cages for the animals. . . He is very helping. Sometimes, when I am trying to do some plumbing but cannot do it, he knows how to fix things around here. He is good at plumbing and at figuring things out.

Disproportionately large numbers of Black and Chicano children are labeled as mentally retarded by the public schools. This phenomenon appears to be true throughout the United States. For example, in California, the rates for placing Chicano and Black children in classes for the mentally retarded are two to four times higher per thousand than the rates for English speaking Caucasian children, whom I will henceforth call Anglos.

We did a study of all the persons labeled as mentally retarded in a city of 100,000 persons in Southern California. We contacted 241 different organizations in the community and asked each organization to give us information on each mentally retarded person being served by that group. The public schools nominated 429 of the 812 persons on the case register and 340 of them had not been nominated by any other organization. When we studied the number of persons jointly nominated by more than one type of organization, the public schools clearly held the commanding position. They not only labeled more persons as mentally retarded than any other organization but they shared their labels more widely throughout the community.

We found that the public schools rely more on IQ test scores than any other community agency. Ninety-nine percent of the persons nominated by the schools had been given an IQ test but only 13% had received a medical diagnosis. We found that 46% of the persons nominated as mental retardates by the public schools had IQ's above 70 and 62% had no reported physical disabilities. All other community agencies, except law enforcement were labeling persons with significantly lower IQ test scores and more physical disabilities. We concluded that the public school system is the primary labeler in the community. The schools label more persons as mentally retarded, share their labels with more other organizations, and label more persons with IQ's above 70 and with no physical disabilities than any other formal organization in the community.

School age children were "over labeled" and pre-school children and adults were "under labeled" compared to their percentage in the general population of the community. Before children get to school, only those with the most physical disabilities and the lowest IQ's are identified. After graduation from school, most of the persons labeled as mentally retarded in the public schools disappear into the general population and are no longer so labeled. Only the most intellectually and physically subnormal adults continue to be regarded as mental retardates.

We found that ethnic disproportions were especially marked among public school nominees. There were 4 1/2 times more Chicano children and twice as many Black children in classes for the mentally retarded as would be expected from their proportion in the population. On the other hand, there were only half as many Anglo children in these classes as we would expect from their proportion in the population. When we studied the labeling process in the public schools, we found that teachers and principals were <u>not</u> referring disproportionately large numbers of minority children for psychological evaluation. Ethnic disproportions first appeared in the labeling process at the point when the IQ test was administered. We also found that the Black and Chicano children who were placed in special education classes had higher IQ test scores and fewer physical disabilities than the Anglo children placed in those classes.

What produces these differences? Some minority parents were convinced that the special education program was deliberately planned to keep minority children from receiving a full education. According to one Black mother whose 14-year-old son had been in special education classes for five years "this program is a conspiracy to keep the minorities down. They put as many as possible in these classes because it means more money for the schools. Many times it's because of racial prejudice or behavior problems. I do know, it's most unfair." We found no evidence in our study that these ethnic disproportions resulted from a conscious policy of discrimination. However, there is no doubt that the labeling process is Anglocentric and weighs most heavily on persons from lower socioeconomic statuses and minority ethnic groups.

These findings lead us to concentrate our efforts on identifying which aspects of the clinical assessment process are producing ethnic disproportions. We studed a representative sample of 6,907 persons from the general population of the community using the American Association for Mental Deficiency definition for mental retardation: mental retardation refers to a person who is subaverage both in general intellectual functioning <u>and</u> adaptive behavior. This is a two-dimensional definition with two primary symptoms: subnormality in intellectual performance and subnormality in adaptive behavior. Combinations of these two dimensions produce the four major types of persons shown in Table 1. The comprehensively retarded are those who are subnormal in both IQ and adaptive behavior. The quasi-retarded are those who are subnormal in IQ but normal in adaptive behavior. The behaviorally maladjusted are those who have normal IQs but are subnormal in adaptive behavior while the normals are those who pass both dimensions. We are concerned primarily with two categories in this typology, the comprehensively retarded and the quasi-retarded.

Table 1
Typology of Mental Retardation

	Intellectual Performance	Adaptive Behavior
Comprehensibely Retarded	Subnormal	Subnormal
Quasi-Retarded	Subnormal	Normal
Behaviorially Maladjusted	Normal	Subnormal
Normals	Normal	Normal

Intellectual adequacy was measured using standarized measures of intelligence, primarily the Stanford-Binet LM and the Kuhlman-Binet. Because there are no generally accepted measures of adaptive behavior, we developed a series

of twenty eight age-graded scales for this purpose. We conceptualized adaptive behavior as an individual's ability to play ever more complex roles in a progressively widening circle of social systems.

We reached three major conclusions in this portion of our study. Our first finding was that the IQ cutoff used by educational institutions in defining mental retardation is one factor producing ethnic disproportions in the labeling process. Three cutoff levels are currently used for defining subnormality--the American Association of Mental Deficiency defines "subnormal" as performance on a standard measure of intellectural functioning which is greater than one standard deviation below the population mean, approximately the lowest 16% of the population (Heber, 1961). Educational practice generally places the dividing line somewhat lower. The highest IQ test score for placement in a class for the educable mentally retarded ranges between 75 and 79, depending upon local usage. This cutoff includes approximately the lowest 9% of the population. The test designers suggest a cutoff that more closely conforms with traditional definitions, an IQ below 70, approximately 3% of the population(Wechsler, 1958; Terman & Merrill, 1960).

We found that the majority of the adults with IQs between 70 and 85 were, in fact, filling the usual complement of social roles for persons of their age and sex: 84% had completed 8 grades or more in school; 83% had held a job, 65% had a semi-skilled or higher occupation, 80% were financially independent or a housewife, almost 100% were able to do their own shopping and to travel alone, and so forth. It is clear that most adults who appear in the borderline category were managing their own affairs and did not appear to require supervision, control, and care for their own welfare. Their role performance appeared neither subnormal nor particularly unusual.

We also found that proportionately more low status persons and persons from minority ethnic groups were defined as comprehensively retarded as the cutoff level for subnormality was raised. When the traditional definition of IQ 69 or below was used, ethnic disproportions were greatly reduced. We concluded that the 3% cutoff, that is, an IQ below 70, was the criterion most likely to identify persons in need of special assistance and supervision and least likely to stigmatize as mentally retarded persons who would be filling a normal complement of social roles as adults. We concluded that persons scoring in the so called "borderline" category should be regarded as low normals rather than as comprehensively retarded.

Our second finding concerned the two-dimensional definition of mental retardation proposed by the American Association for Mental Deficiency. Although this definition requires subnormality in both intellectual performance and adaptive behavior, in actual clinical practice, most psychologists give only an IQ test when making assessments. Would it make a difference if psychologists also evaluated adaptive behavior?

We compared the social role performance of the quasi-retarded, i.e., those who failed only the IQ test, with the comprehensively retarded, i.e., those who failed both the IQ test and the adaptive behavior scales. We found that most quasi-retarded school age children, in spite of their low IQ test score, had avoided falling behind their age mates or being placed in special programs. We found that 80% of the quasi-retarded adults had graduated from

high school; they all read books, magazines, and newspapers; all had held jobs; 65% had white collar positions. All of them were able to work without supervision; participated in sports; traveled alone; went to the store by themselves; and participated in informal visiting with co-workers, friends, and neighbors. In other words, their social role performance tended to be indistinguishable from that of other adults in the community.

We found that a large percentage of persons in the quasi-retarded category were Chicano and Black. We found that 60% of the Chicanos and 91% of the Blacks who had IQ test scores below 70 passed the adaptive behavior measure while none of the Anglos with IQs this low were performing normally in their social roles. The IQ test is not as valid a predictor of social role performance for Chicanos and Blacks as for Anglos. Thus the evaluation of adaptive behavior was especially important in assessing persons from ethnic minorities and lower socioeconomic levels, persons from backgrounds that do not conform to the average sociocultural pattern of the community. Many of them may fail IQ tests mainly because they have not had the opportunity to learn the cognitive skills and to acquire the knowledge needed to pass such tests. They demonstrate that they are not comprehensively incompetent by their ability to cope with problems in other areas of life. We concluded that the schools should adhere to the AAMD definition of mental retardation and should develop a systematic method for measuring adaptive behavior as well as IQ in making psychological assessments. We concluded that a child ought to fail both criteria before being labeled as mentally retarded. When we followed this procedure, ethnic disproportions were reduced but still were not completely eliminated.

Our third major conclusion dealt with cultural biases in IQ tests. The IQ tests now being used by psychologists are, to a large extent, Anglocentric. These tests tend to measure the extent to which a child's family background is similar to that of the middle class Anglo-American core culture. We found that approximately 32% of the differences in IQ tests scores among a sample of approximately 1,5000 Black, Chicano, and Anglo elementary school children in one California school district could be accounted for by differences in the sociocultural characteristics of their families. We concluded that sociocultural factors should be taken into account when interpreting the meaning of any child's IQ test score.

To do this, we grouped each Black and Chicano elementary school child in our sample into one of five groups according to the extent to which his family background conformed to the average configuration for the total community. Each child was given one point for each family characteristic which was like the dominant society on the five most important sociocultural variables which we found were correlated with Full Scale WISC IQ for his ethnic group. If his family was similar to the dominant society on all five characteristics he received a score of five. If his background was similar to the dominant society on four characteristics he received a score of four, and so forth.

The drawings in Figure 1 depict the IQ scores of the Chicano children in the five sociocultural groupings and compare them with the distribution of IQ scores for the Anglo children on whom the test was standardized. The average IQ for the entire group of Chicano children was 90.4. The 127 children

Figure 1

Convergence of the Average IQ Test Scores of Chicano Children with the Standard Norms as Sociocultural Factors are Increasingly Controlled

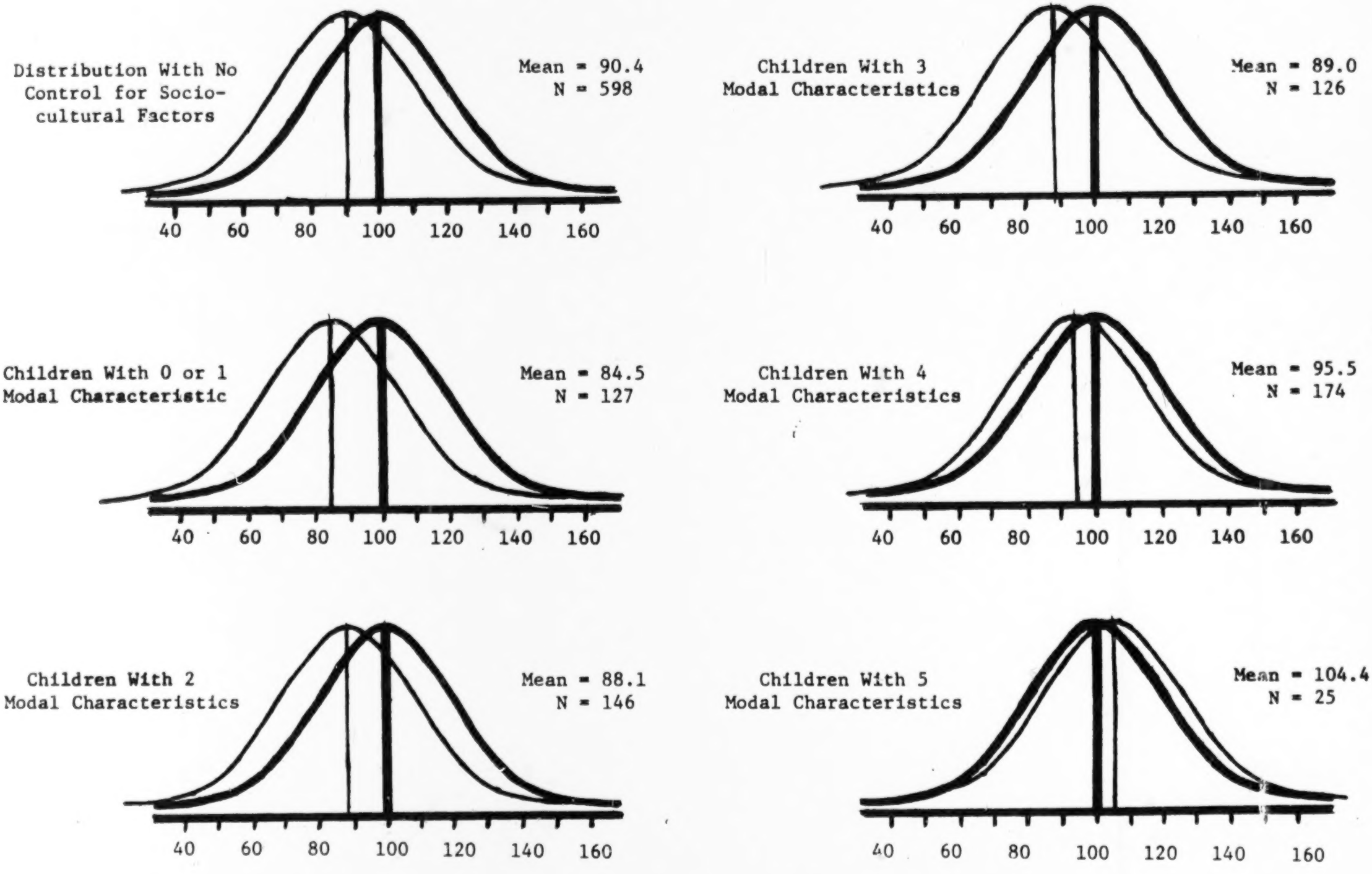
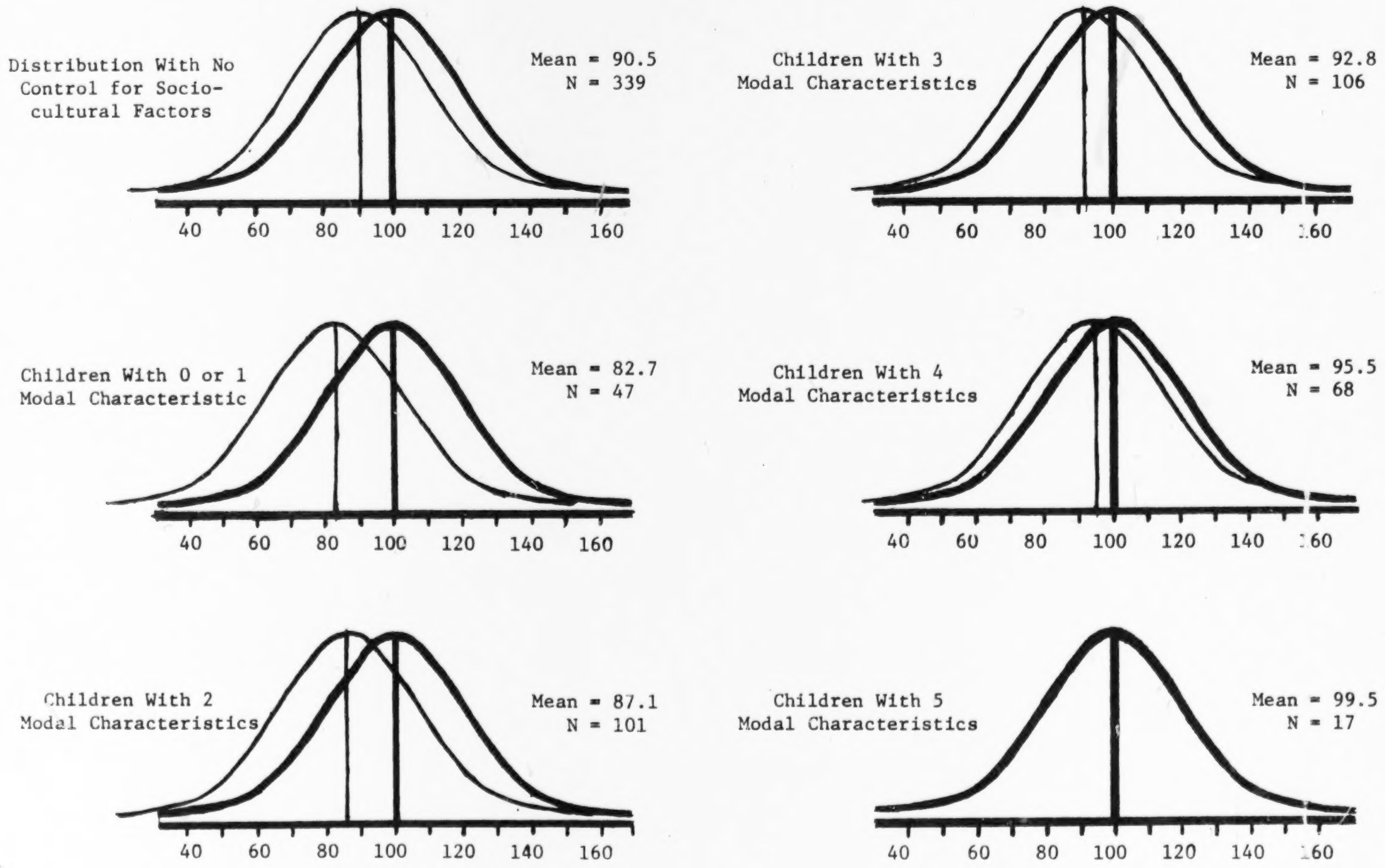

Distribution With No Control for Socio-cultural Factors
Mean = 90.4
N = 598
40 60 80 100 120 140 160
Children With 3 Modal Characteristics
Mean = 89.0
N = 126
40 60 80 100 120 140 160
Children With 0 or 1 Modal Characteristic
Mean = 84.5
N = 127
40 60 80 100 120 140 160
Children With 4 Modal Characteristics
Mean = 95.5
N = 174
40 60 80 100 120 140 160
Children With 2 Modal Characteristics
Mean = 88.1
N = 146
40 60 80 100 120 140 160
Children With 5 Modal Characteristics
Mean = 104.4
N = 25
40 60 80 100 120 140 160

Figure 2

Convergence of the Average IQ Test Scores of Black Children with the Standard Norms as Sociocultural Factors are Increasingly Controlled


Distribution With No Control for Socio-cultural Factors
Mean = 90.5
N = 339
Children With 3 Modal Characteristics
Mean = 92.8
N = 106
Children With 0 or 1 Modal Characteristic
Mean = 82.7
N = 47
Children With 4 Modal Characteristics
Mean = 95.5
N = 68
Children With 2 Modal Characteristics
Mean = 87.1
N = 101
Children With 5 Modal Characteristics
Mean = 99.5
N = 17
40 60 80 100 120 140 160

from backgrounds least like the dominant society, those having zero or 1 modal characteristic, had an average IQ of 84.5, borderline mentally retarded by the American Association for Mental Deficiency definition. The 146 children with two modal background characteristics had a mean IQ of 88.1; those with three characteristics a mean IQ of 89.0; those with four characteristics a mean IQ of 95.5; and those with all five modal characteristics has a mean IQ of 104.4. When social background was held constant there was no difference between the measured intelligence of Mexican-American children and the Anglo children on whom the test was standardized.

Figure 2 shows that the situation is just as dramatic for Black children. The total group of 339 Black children had an average IQ of 90.5 when there was no control for sociocultural factors. The 47 children who came from backgrounds least like the dominant community had an average IQ of 82.7. Those with two modal characteristics had an average IQ of 87.1. Those with three characteristics had an IQ 92.8; those with four characteristics had an IQ of 95.5; and those with five characteristics an IQ of 99.5, exactly at the national norm for the test. Thus, Black children who came from family backgrounds comparable to those of the middle class Anglo community did just as well on the Weschler Intelligence Scale for Children as the children on whom the test was standardized. When sociocultural differences were held constant, there were no differences in measured intelligence.

We concluded on the basis of our study, that diagnostic procedures in the public schools should be broadened to reflect the pluralistic nature of American society. We are proposing the development of pluralistic assessment procedures which involve securing information beyond that ordinarily considered in public school assessment. Our findings suggest that only persons in the lowest 3% of the population, that is with IQs under 70, should be labeled as comprehensively retarded. Our findings also suggest that information about adaptive behavior--a child's ability to cope with problems in the family, neighborhood, and community--should be considered as well as his IQ test score when making a clinical assessment. Only persons who are subnormal <u>both</u> on the IQ test and in adaptive behavior should be regarded as comprehensively retarded. Finally, in pluralistic assessment, the meaning of a particular IQ test score or adaptive behavior score should be interpreted not only within the framework of the standardized norms based on a sample of Anglo children but should also be evaluated in relation to the norm for the sociocultural group to which the child belongs. His position on the standard norms indicate how well he is likely to do in a regular public school classroom with no special assistance. His position on the norms for his own sociocultural group indicates his probable potential for learning.

When we reanalyzed the data from our survey of mental retardation in the community using pluralistic diagnostic procedures, ethnic differences in rates for mental retardation disappeared. Approximately the same percentage of persons in each ethnic group were identified as comprehensively retarded. We re-evaluated the 268 children who were enrolled in classes for the educable mentally retarded in two Southern California school districts using pluralistic diagnostic procedures. We found that approximately 75% of the children in those classes would not have been labeled as comprehensively retarded if their

adaptive behavior and their sociocultural backgrounds had been taken into account at the time they were evaluated.

Table 2 shows the percentage of each ethnic group in each category before and after re-evaluation. Although 75% of the children in the two school districts were Anglo, only 50% of the children in classes for the educable retarded were Anglo. Approximately 25% were Chicano and 25% Black. When sociocultural characteristics were taken into account, the distribution by ethnic group in the category of the mentally retarded closely approximated the distribution for the population of the two school districts. More Black and Chicano children were reclassified as quasi-retarded, behaviorally maladjusted, or low normal. Significant numbers of Anglo children were also reclassified into those categories. Based on this experience, we are proposing that pluralistic assessment procedures be developed and be used systematically in the evaluation of children from non-modal sociocultural backgrounds.

We turn now to the second major issue to be discussed this evening--that of the stigmatization associated with present labeling and placement practices. Stigmatization was a major concern of parents we interviewed. Many freely expressed their feelings about the special classes and their distress at the psychological consequences for their children of being placed in classes for the educable mentally retarded. One Black mother told our interviewer:

> I feel that if a child is put in a special education class in elementary school, by the time he gets to junior high he should be removed because there is a stigma that goes with a special class. Let's face it, children can be real cruel. I feel for the most part the youngsters that are in those classes and retained suffer a great emotional handicap. It's as if they have a sign around their necks for everyone to read. Bill is being retarded in special education. He doesn't like being labeled as retarded. It's affecting him. He begs us to have him removed from that class.
>
> We have to make Bill go to school because that class does not offer a challenge to him. What they do is repetitious--the same thing over and over... He does not like school. We have to make him go. The only reason he consents to go is because we have been promised that he'll be taken out of that EMR class. The teachers have asked us to let them put another one of our kids in EMR. We said an emphatic "no!" because we knew what it was all about.

Maria is a 13-year-old Chicano girl who has been in special education classes ever since she was eight years old. She has a full scale IQ of 62. Her mother told the interviewer that Maria does not want to go to school and goes up to her room and hides until the school bus goes away. She knows that her mother cannot take her because her mother does not drive. Maria's mother said that she was very sorry she had signed the papers and that she is not

Table 2

Reclassification Resulting from the
Application of Pluralistic Assessment Procedures in
Re-evaluating 268 Labeled Retardates in the Public Schools

Ethnic Distribution	Physically Handicapped Mental Retardates	Non-Physically Handicapped Mental Retardates	Quasi-Retarded	Behaviorally Maladjusted	Low Normals	Total
	(32)	(37)	(39)	(78)	(82)	(268)
% of Anglo	84.3	70.2	61.5	41.0	32.9	54.0
% of Chicano	6.2	16.2	17.9	20.5	40.2	23.0
% of Black	9.3	13.5	20.5	38.4	26.8	23.0

going to sign the paper for the other boys that the school wants to put in special education. She did it once but is not going to do it again.

Parents reported that their children were ashamed to be seen entering the "MR" room because they were often teased by other children about being "MR." The children dreaded receiving mail that might bear compromising identification. They could not understand why they were classified with Anglo children who were physically handicapped when they had no physical disabilities.

Parents were also concerned with the third issue which I would like to discuss this evening--the quality of the educational program in the self contained special education class. Parents asked why their children were not taught to read like they would be taught in the regular classes. Many parents saw the program as a "sentence of death." We found several parents, like the parents quoted earlier, strenuously resisting the efforts of the school to place younger children in special education classes because they had found it to be an inescapable dead end for their older children. Our findings confirmed their suspicions. We followed a group of 108 children for several years. Only one child in five ever returned to the regular class. The remaining children either aged out of the program, dropped out of school, or were sent to other special programs or institutions.

During the past twenty years, one of the great achievements of public education in American has been the devlopment of special education programs designed to meet the special needs of handicapped children. It would be a tragedy if these valuable programs were to be jeopardized because of inadequacies in assessment procedures and programming. I believe there are viable alternatives to present practices. Assessment procedures can be modified to take sociocultural factors into account and programming can be altered to reduce stigmatization and to keep many children who are now in self contained special education classrooms in the educational mainstream.

First, I believe school psychologists should be required to enlarge the scope of information they use in making educational decisions. They should regularly and systematically secure information about the child's adaptive behavior in non-school situations--at home, in the neighborhood, and in the community. If a child is performing adequately in these settings, then it is clear that his problems are school specific and that he is not comprehensively retarded. His program should be planned with the expectation that he will probably be able to fill his adult roles acceptably and that his primary needs are for special help with academic tasks. For him, special tutoring, programmed learning, cross-age teaching, remedial reading, or similar programs are to be preferred to the self contained classroom and a curriculum for the mentally retarded.

In addition to adaptive behavior, I believe that school psychologists should be required to secure systematic information about a child's sociocultural background which can be used in interpreting the meaning of his IQ test score. Pluralistic norms should be developed so that a child's performance can be compared not only with the performance of the general population, which is composed primarily of Anglo children, but can be compared with the performance of other children from his own sociocultural background. Children from comparable backgrounds would have had similar opportunities to acquire the skills and knowledge covered in the tests. Thus, children whose low performance is primarily the result of sociocultural differences, would be identified and could receive appropriate educational assistance.

I do not agree with those who say we must stop all educational labeling. The human mind needs concepts and language in order to think and plan. Classifying persons according to significant characteristics and giving each group a name is essential to conceptualization and to planning effective educational treatments. Our problem in the past has not been that we have done too much labeling. Our problem has been that there have been too few labels and they have been too crude. We have grouped a large number of children with widely different characteristics and very different needs under one label, the mentally retarded, and have given them on undifferentiated program. What is needed is a more sensitive system for identifying children in need of specific education programs and a whole continuum of special education programs carefully targeted for children with specific needs.

Special education programs should be planned on the premise that every child be kept in the educational mainstream if at all possible. The self contained classroom should be a treatment reserved only for the comprehensively retarded.

Figure 3 presents, schematically, how such a continuum of special education programming might look. At the far right are those children in the regular classroom who need no special help beyond the regular classroom program. The next group, to the left, are those children who can be maintained full time in the regular classroom if they are given some additional individual help by tutors, mother helpers, cross-age tutors, or other persons working under the direction of the regular classroom teacher.

The next group consists of those children who need more intensive assistance with a special education teacher for a few hours a week outside of the regular classroom. Children in this group would be those who need remedial reading, English as a second language, or other types of programs requiring special teaching skills. Closely related to this group are those children who may have regular, daily periods in a resourse room, a crisis room, or other special program but are still, primarily, enrolled in the regular academic classroom.

The four categories to the extreme left are heavily weighted toward special education. However, even within the special education program, there can be differentiated treatments. Some children may have a program split between regular and special classes, sharing music, art, physical education, and other non academic classes with the regular students. The comprehensively retarded would spend their entire day in a self contained special education classroom and program while still remaining in the same school building with their brothers and sisters and neighbors and friends. Only the comprehensively retarded with physical handicaps or other needs which require a specially designed physical plant would be isolated in self contained special schools or institutions.

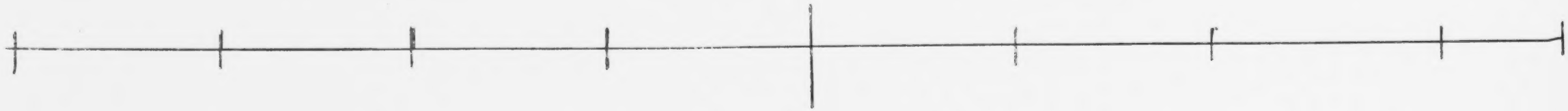
One of the most distressing current developments in special education in some regions of the United States has been the precipitous reassignment of many children to the regular classroom program and self contained classrooms with no provisions for a continuum of special education services to meet their needs. It would be a great leap backwards if, as a result of modifying assessment procedures, we eliminate programs needed to serve children. Relabeling is not some magic panacea which suddenly enables children from socio-

Figure 3

Schema for Conceptualizing a
Continuum of Special Education Services

Special Education Program | Regular Academic Program

Institution-alization	Self-Contained Special Education School and Program	Self-Contained Special Education Classroom and Program	Split Regular Special Education Program		Regular Classroom with Resource Teachers	Regular Classroom Full time
			Music, Art, P. E. ect. in Regular Class	Daily Sessions with Special Resource Teachers, Crisis Rooms, etc.	A Few Hours a Week in Resource Rooms, Remedial Reading, Bilingual Program, etc.	Tutors, Cross Age Teaching, Programmed Learning, etc.	No Special Help



culturally non-modal environments to achieve in a regular educational program. It is essential that the children who received and were eligible for special education in the past continue to receive special education. It is essential that money be provided to continue support for special education programs for them. Changes in the types of assessment and the types of programming must not be used as excuses for saving money by eliminating programs. Instead, the financial support and the effort of special education teachers should be redirected into providing a wider variety of special services and programs geared to keeping as many children as possible in the educational mainstream and educating each child to his own maximum potential.

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